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A metasynthesis of risk perception in women with high risk pregnancies

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ABSTRACT

Introduction: risk perception in women with high risk pregnancies affects their decisions about perinatal care and is of interest to anyone involved in the care of pregnant women. This paper provides a metasynthesis of qualitative studies of risk perception in women with high risk pregnancies.
Methods: a systematic search of eight electronic databases was conducted. Additional papers were obtained through searching references of identified articles. Six studies were identified that reported qualitative research into risk perception in relation to high risk pregnancy. A metasynthesis was developed to describe and interpret the studies.
Findings: the synthesis resulted in the identification of five themes: determinants of risk perception; not seeing it the way others do; normality versus risk; if the infant is ok, I'm ok; managing risk.
Conclusions: this metasynthesis suggests women at high risk during pregnancy use multiple sources of information to determine their risk status. It shows women are aware of the risks posed by their pregnancies but do not perceive risk in the same way as healthcare professionals. They will take steps to ensure the health of themselves and their infants but these may not include following all medical recommendations.

Contents

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Introduction

High risk pregnancies are those complicated by a factor which threatens the well-being of the mother and/or fetus. Women whose pregnancies are diagnosed as high risk may experience many emotions including fear, anger, loneliness, frustration and hope (Loos and Julius, 1989; McCain and Deatrick, 1994; Leichtentritt et al., 2005). Exactly how they feel about the pregnancy will be affected by how they perceive the level of risk. Studies of risk perception show an individual's perception of risk is a subjective response based on previous life experiences, coping strategies, the context in which the risk occurs, the degree of perceived control, and the weight attached to information about the risk obtained from a variety of sources (Edwards et al., 2002; Alaszewski and Horlick-Jones, 2003; Gray, 2006). This is also true of risk perception in pregnancy (White et al., 2008; Jordan and Murphy, 2009).

How women with high risk pregnancies perceive their risks will affect their behaviour in pregnancy and their decisions about perinatal care. Knowledge of women's risk perception is therefore important for professionals involved in their care. However, a systematic review of seven quantitative studies of risk perception suggests pregnant women and healthcare professionals do not perceive pregnancy risk in the same way. The review found results were inconsistent for the association between women's perceived risk scores and healthcare professionals' ratings of risk for women with high risk pregnancies (Lee et al., 2012). Qualitative research can provide a more detailed understanding of the complex factors which influence women's perception of risk. A metasynthesis will provide a comprehensive study of work in this area.

Differences in perception of risk may result in misjudged and misinterpreted communication between healthcare professionals and pregnant women and a subsequent lack of satisfaction with healthcare provision (Searle, 1996). This is an issue of concern as women with high risk pregnancies represent a group with which professionals may already have difficulty communicating. For example, in a qualitative study of 17 healthcare professionals involved in the care of women with high risk pregnancies, 15 reported experiencing communication difficulties for reasons including powerlessness, anxiety and lack of time (Pozzo et al., 2010).

Differences in risk perception between women with high risk pregnancies and health care professionals may occur for several reasons. Women may lack knowledge e.g. Chuang et al. (2010) found non-pregnant women suffering from diabetes, hypertension or obesity were not aware of all of the risks these conditions posed during pregnancy. Women may choose to rely on their own understanding of their symptoms rather than medical diagnoses. Thus pregnant women diagnosed with hypertension, a condition which increases risks to the mother and fetus, but without symptoms of the condition, reported feeling fraudulent accepting medical care and found it difficult to follow treatment plans (Barlow et al., 2008).

What women with high risk pregnancies want from their relationship with health professionals may also not coincide with what professionals think is important or possible in the relationship. In a study by Pozzo et al. (2010), professionals who reported difficulties communicating with women also noted that women had asked for greater emotional closeness and empathy. In another qualitative study of women with high risk pregnancies and professionals involved in their care it was found that women placed a great deal of emphasis on hope (Roscigno et al., 2012). They wanted realistic information and did not think they were denying the risks of the pregnancies but hope was viewed as a positive source of strength in difficult circumstances. In contrast the professionals thought it was important to realistically portray potential negative outcomes. Whilst they stated they did this in a non-directive manner, this was not the women's interpretation of the experience. Similarly, in a qualitative study of what constituted quality of care in pregnancy, women cited three requirements from information from midwives: that it helped them to prepare for parenthood; it enabled them to make informed choices; and was a source of reassurance. Midwives identified the first two of these needs as important to women but not the need for reassurance (Proctor, 1998).

How women use the information they are given during pregnancy may also reflect their priorities, which may be different to those of healthcare professionals. In a qualitative study of decision making in pregnancy, Levy (1999) found a key activity for women was maintaining equilibrium. This meant decisions had to balance the needs of the fetus with the needs of the woman and her partner, other children and wider sphere of life. Women prioritised the needs of the fetus but they also weighed up the effects of recommended treatments on their existing families. They then modified treatment plans according to what they believed best for their individual circumstances. Women generally prefer a process of shared control of their care with medical professionals and value this when it is offered (VandeVusse, 1999). If it is not offered, women utilise a variety of strategies including challenging health professionals, negotiation, and appearing to accept recommendations during the consultation but then modifying them as they feel appropriate (Levy, 1999; VandeVusse, 1999). Their responses may also differ with time. Durham (1999) found women with high risk pregnancies would initially comply with treatment plans when their condition was newly diagnosed and anxiety levels were high. However, after some time elapsed and their conditions had not notably worsened, the women negotiated modifications to their treatment in order to accommodate what they felt were realistic adjustments within the context of their circumstances. Thus women in these studies were aware of the risks as described by healthcare professionals but did not necessarily respond to them in the way the professionals recommended.

Although women may not adhere to recommended treatments they do want to be informed about the risks they are facing. In the study by Pozzo et al. (2010), 92% of participants wished to be kept informed even if there was uncertainty about what was going on. Levy (1999) found women wanted information about their pregnancy although they would avoid information they were unable to act on or they perceived as irrelevant. Women also wish to be involved in making decisions about their care. A qualitative study of women with high risk pregnancies showed 30 of the 47 participants wished to be involved in decision making. Following the birth of their children, five of the remaining 17 women said that in future pregnancies they would also want to take a more active role in their care (Harrison et al., 2003). Shared decision making in pregnancy is also associated with more positive emotions on the part of women (VandeVusse, 1999).

Women with high risk pregnancies may therefore not perceive risks in the same way as healthcare professionals or act on them in the way professionals recommend. This discrepancy may cause frustration on both sides if not dealt with sensitively. Professionals may not be able to judge which women are less satisfied with the care they are receiving as doctor satisfaction levels following consultation are not correlated with service user satisfaction levels (Zandbelt et al., 2004). There is also no correlation between doctors' perception of service user satisfaction and service users' actual satisfaction scores (Merkel, 1984). Service user satisfaction is an important consideration because it is associated with adherence to treatment (Schneider et al., 2004). If women feel their concerns are unacknowledged they may be less willing to engage with healthcare services, potentially increasing the degree of risk.